AUTHORIZATION FOR THE RELEASE OF PROTECTED MEDICAL INFORMATION

PARTICIPANT NAME:

DOB:

SOCIAL SECURITY#:

1. The following organization, or health care provider, is authorized to disclose the above-named individual's health and personal information as described in this authorization form:
    a. Harrison County Community Corrections
    b. Harrison County Home Incarceration

2. The following person, or organization (and agents, employees, and representatives of such person or organization) is authorized to receive and/or use the information:

    a. Harrison County Circuit Court, Harrison County Magistrate Court, Harrison County Prosecuting Attorney's Office, the Harrison County Community Corrections Program, Harrison County Home Incarceration, and the Division of Justice and Community services; and/or
    b. Other: _____.

3. The description and amount of information to be disclosed is as follows:
    a. Any and all records, reports, summaries, notes, billing records, and any information regarding the examination, evaluation, care and treatment (including alcohol and drug abuse treatment) of the above –named individual. This includes all the transmissions of information and data via verbal and electronic, notes of conversations, phone call(s), memoranda, and/or any type of communication concerning the overall treatment of the above-named patient.
    b. START DATE of SERVICE: _____

4. The information may be used, or disclosed for the following purposes:
    a. The purpose of pending criminal actions involving the above-named individual, including, but not limited to, disclosures in the course of judicial and administrative proceedings. These permitted disclosures include providing reports of the Court and Officers of the Court regarding the above-named individual's compliance, or noncompliance, with Court Orders. Disclosures may also be made to the Justice and Community Services Division of W.Va. Homeland Security to the extent that the Community Corrections Subcommittee of the Governor's Committee on Crime, Delinquency and Corrections may effectuate its obligations pursuant to W.Va. Code § 62-11C-3(b)(1) and other similar statutory authority.

5. I authorize the release of records pertaining to (please initial):
   _____ Behavioral or mental health services
   _____ Treatment for alcohol and/or drug abuse
   _____ Other: _____
   _____ I understand that any disclosure made is bound by part 2 of Title 42 of the Code of Federal Regulations, governing confidentiality of alcohol and drug abuse patient records and that the recipients of this information only re-disclose it only in connection with their official duties.

6. This authorization expires one year from the date of signature, if not otherwise indicated.
7. I understand that the requested health care information may be protected under HIPAA. For the purposes of this authorization, I hereby waive my rights under HIPAA and requested that such information be released to the treating Community Correction Program, the Justice and Community Services Division within the Department of Homeland Security, the ordering Court, and the prosecuting attorney's office, or their authorized representative, and any other party specified above, with the knowledge that these records may be reviewed subsequently by others as part of the Community Corrections Programming and/or the accompanying judicial processes.
8. I understand that I may inspect and receive a copy of this authorization.
9. I understand that I will not be refused treatment simply because I do not sign this authorization, unless I have agreed to receive the treatment as part of a research project, or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign the authorization may result in a refusal to provide treatment.
10. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance upon this authorization. My revocation will not be effective until I submit a written request to revoke the authorization to the organization, or provider who has been authorized to release my records pursuant to this authorization. I also further understand that my revocation will not circumvent the Court from ordering certain disclosures as they relate to my compliance with previous Orders of the Court.
11. This authorization does not permit any agent, employee or representative of _____ to discuss records, or medical treatment with any physician, hospital, or clinic personnel, without my prior written consent, but only permits and authorizes the release of copies of the complete medical file by such physician, hospital, pharmacy, or clinic.
12. A photocopy of this authorization is to be used and considered as having the same effect as the original of said authorization.

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____